

Research article

Psychosocial primary care – what patients expect from their General Practitioners A cross-sectional trial

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Abstract

Background: Psychosocial Primary Care (PPC) is a model of service delivery for patients with mental disorders and psychosocial problems which was established in Germany in 1987. This study was performed as part of the evaluation of a PPC training program. We investigated patients' expectations of the psychosocial treatment offered by GPs trained in PPC.

Methods: Ten general practitioners trained in PPC were randomly selected. Two hundred and twenty patients were surveyed in the waiting room regarding their expectations concerning psychological treatment.

Results: Eighty-five per cent of patients could envisage making use of psychosocial treatments. Counselling by the GP was considered most important (65%). Fifty-four per cent of patients indicated that there was sufficient counselling, but further distinctions revealed dissatisfaction with both the extent and content of the counselling. Lack of time was the most frequent reason (53%) cited for insufficient counselling. A willingness to discuss the psychological aspects of illness was exhibited by between 55% (current illness) and 79% of patients. Two-thirds of patients believed that discussing psychological aspects and counselling by the doctor could exert a healing effect or contribute to symptomatic improvement in physical illnesses. Younger patients and patients with experience in psychotherapy expected referral to mental health services.

Conclusions: Primary care patients desire and accept psychological treatment from their GP. Training in psychosocial competence in primary care should be offered more frequently.

Background

In Germany, the prevalence of mental disorders and psychosocial problems within the framework of primary care is between 20 and 30% of all patients of general practitioners (GPs); this provides an indication of the requirement for treatment. The most frequent diagnoses of

mental disorders seen in general practice are somatoform disorders, non-specific depressive symptoms, adjustment disorders or other neurotic disorders of mild or moderate severity.

In Germany, psychiatric and psychosomatic care are separately provided. Since 1994 psychotherapy has been part of training in psychiatry. Referral to psychiatry is usually for clarification and treatment of psychoses, addictions, psychotropic drug treatment and short-term psychotherapy. Patients with neurotic disorders, personality disorders or specific problems like eating disorders are referred to medical or psychological psychotherapists, who are specially trained for these disorders.

The origins of psychosomatic medicine in Germany predominantly lie in internal medicine and psychodynamic psychotherapy rather than in psychiatry, and psychosomatic medicine was often in conflict with or opposition to psychiatry. It has been firmly established as a distinct clinical speciality in medical schools since the 1970s with its own inpatient and outpatient facilities and teaching and research obligations. In 1987, Psychosocial Primary Care (PPC), a new model of service delivery provided by GPs, was approved as reimbursable by health insurances. In order to be reimbursed for this service, GPs are required to undergo 80 hours of advanced training in PPC which includes 20 hours of theory, 30 hours of intervention techniques and 30 hours of Balint group.

PPC addresses three targets: 1. Early recognition of psychosocial problems, especially in patients with complex physical illnesses. 2. An efficient and limited time period of psychosocial treatment by the GP (counselling and relaxation techniques). 3. Assessment of indications and motivation for referral to outpatient psychotherapy and further cooperation with other mental health services.

It is extremely important to take the expectations of patients into account in future planning of mental health care [1]. The expectations connected with psychosocial treatment are dependent on sex [2], age [3] and level of education [4].

Patients express a great deal of dissatisfaction with respect to the amount of counselling provided by their GPs [5]. However, the time factor is not necessarily the reason for not addressing personal problems. The following reasons were found on the patient side: lack of trust, shyness, shame, doctors' business is only medical, feelings of rejection, could deal with the problems themselves, the doctor could not help, it was not important for healing, bothered the doctor too much, or they simply did not have any problems [5–8]. In particular, older people exhibit a tendency not to criticize and consequently not to demand anything [8], with the result that older patients appear to be content, even if their problems are not addressed or only partially addressed.

Consequently, the following questions are posed for this work:

1. What offers of psychosocial treatment do patients expect from their GPs?
2. How important do patients consider the opportunity to talk about the "psychological aspects" of their illnesses?
3. How strongly do treatment expectations depend on sex, age and level of education?
4. What is the value placed on offers of psychosocial treatment within the overall care provided by GPs?

Methods

General Practitioners

The patients of 10 GPs were surveyed. All of the doctors took part in further training for PPC and were either GPs or general internists working as GPs. Three GPs had rural practices, four GPs worked in small towns whilst three GPs practised in the city of Freiburg. The doctors were randomly chosen from among 200 participants in a PPC course. Participants were contacted consecutively for study recruitment with the sample size of 10 being achieved after 14 contacts. Four doctors, 3 of them women, declined to participate.

The 10 GPs (mean age 43 years) had practised medicine for an average of 15 years, with 6 years in their own practice. There were more male than female participants (3 women, 7 men). One family physician practiced homeopathy.

Measurements

The topic of the investigation was explained to the patients and the anonymity of their answers was guaranteed. The study was approved by the Ethics Review Committee of the University of Freiburg and informed consent was given by all participants. The survey was a structured paper and pencil questionnaire for the patient with questions being drawn from the literature and after carrying out ten exploratory interviews. Support in filling out the questionnaire was given by one of the authors (U.A.) for patients, especially the elderly, who had difficulties in reading or understanding the questions.

The main questions were as follows:

What kind of help should the GP offer for psychological problems?

Would you consider making use of some of the following psychosocial treatment offers?

How important is it to talk about psychological aspects of your illness? How important is it to talk about psychological aspects in general?

Do you believe that talking about psychological problems, life stress or worries can contribute to healing or relieving an illness?

If there is "never" or only "insufficient" conversation with your doctor about your psychological problems and worries, what is the reason?

Patients

All patients were recruited on two different days in the waiting room during office hours. Of a total of 337 patients, 220 patients agreed to participate. Fifty-three patients refused to participate whilst 24 patients could not answer the questions for reasons of health or inadequate understanding of German. Only 5 of 37 patients who took the questionnaire home because of lack of time returned the questionnaire. Eight patients submitted incomplete answers.

The patients were distributed among the 10 doctors. With the exception of the doctor who had additional training in homeopathy, there were no differences in the patient groups of the various doctors.

Statistical Method

The evaluation was carried out using the SAS (Statistical Analysis System). The Chi²-test was used to determine statistical significance. The significance level was set at 0.05. The Pearson correlation coefficient is given in correlation calculations. The subgroups were tested for differences in all variant variables since the patients were clustered within the individual practices and selection artefacts can be assumed.

Results

Sociodemographic Data

The data we recorded were compared to the study by Tress et al. [9], which examined psychological problems and their management in primary care in Germany (see table 1). There were no differences between the individual practices.

The average age and the distribution of gender were equivalent to those in the EVaS-Study [10] and the WHO-Study that examined outpatient medical care in Germany [11].

Patient problems (main complaints)

The main complaints in descending order of prevalence concerned the following organs and systems: back (6.8%), gastrointestinal (5%), heart (5%), muscles and bones (4.5%), skin (4.5%), throat disorders (4.1%),

Table 1: Sociodemographic Data

	Fritzsche et al. n = 220	Tress et. al [9] n = 572
Known to the GP	94%	-
Age (M) (SD)	44.5 ± 17.5	± 15.7
Gender (F)	59.5%	68.7%
Level of education		
None	6.5%	1.9%
High school	31%	46%
College	16%	10%
Trade school	31%	38%
University	7%	7.5%

coughing and bronchitis (3.2%). This was comparable to the distribution in the EVaS-study [10].

Additional organ-related symptoms such as headache or micturition problems occurred with a frequency between 0.5 and 3% and were reported by 28% of patients. Non-specific symptoms such as dizziness or fever were present in 15% of patients. Forty-five patients (21%) either came for a check-up with their children or could not exactly describe their complaints. These patients did not record any main complaints.

The existence of "psychological problems" was cited by 3.2% which is comparable to both the EVaS-study (3.0) and the study by Tress et al. [2] (3.5%).

The percentage of patients with psychological problems increased to 20.5% (n = 45) when any present and past experience with psychosocial care by mental health specialists was included. Patients with previous experience in psychotherapy were significantly more frequently women between 20 and 40 years of age with higher education.

Expectations of psychosocial care and its potential utilization

Table 2 shows patient interest in seven aspects of psychosocial treatment. There is a great desire for both psychosocial treatment from the GP and referral to mental health specialists. The willingness of patients in the homeopathic practice to probably or definitely accept an offer of treatment was significantly higher.

Patients (n = 91) who already had experience with one or more treatments by mental health specialists would also make use of such treatment if they needed it. The difference between people who had prior experience with psychotherapeutic treatment versus those who had no such

Table 2: "What kind of help should the doctor be able to offer for emotional problems, and what help would you probably or definitely accept?"

	Yes	Definitely Accept	Accept
Psychosocial care in general	74 %	67 %	18 %
Counseling by GP	65 %	43 %	25 %
Partner/family counseling	28 %	23 %	17 %
Relaxation techniques	51 %	30 %	16 %
Self-help groups	42 %	17 %	27 %
- mental health services	43 %	21 %	
- psychotherapy	56 %	30 %	14 %

experience was significant for each treatment measure ($p < 0.001$).

The importance of talking about psychological aspects of the illness with the GP

We distinguished here between "acute main complaints" ($n = 180$) and illnesses "in general" ($n = 220$). Seventy-nine per cent considered a talk with their doctor about psychological aspects of their illnesses and their personal worries important (47%) or very important (32%) "in general". In addition, 55% of patients considered this to be either important (35%) or very important (20%) for their current illness.

Were the psychological aspects of their acute main complaints discussed sufficiently?

Fifty-four per cent found that psychological aspects of their acute main complaints were discussed "sufficiently". However, 18% found the discussion "insufficient" whilst 28 per cent indicated that psychological aspects of their complaint were "never discussed". Patients who stated that discussion was insufficient were almost all from the group who found discussion important or very important in principle.

Table 3 lists the reasons why patients "never talked" to their doctors about psychological problems as well as the reasons why patients found the discussion of the problem by the doctor to be "insufficient".

Expectations related to healing and relief

Eighty per cent of the patients considered that counselling by their doctors could contribute to healing or relieving an illness. Forty-five per cent believed that it depended on the type of illness. Twenty-nine per cent said there was "always" an influence and 6% limited the discussion to "purely psychological" illnesses. Eleven per cent did not

Table 3: Reasons Why "Never" Talk or Talk "Insufficiently" with the GP about Psychological Problems.

	"Never" ($n = 21$)	"Insufficiently" ($n = 56$)
I have no problems	81% ($n = 17$)	24% ($n = 13$)
Other confident partners	24% ($n = 5$)	23% ($n = 12$)
Lack of time	-	53% ($n = 30$)
Too much stress for the doctor	5% ($n = 1$)	16% ($n = 9$)
No opportunity	-	18% ($n = 10$)
Afraid to talk to	-	11% ($n = 6$)
Doctor not interested	-	11% ($n = 6$)
No confidence in the doctor	-	7% ($n = 4$)
None of the doctors business	-	4% ($n = 2$)

Note: This question was based on a multiple response format

believe in such an effect, but thought that counselling would make them feel good as it was a signal that "somebody cares". The importance of counselling correlated moderately with the evaluated benefits – healing or relieving ($r = 0.35$, $p < 0.001$).

Expectations dependent on sex, age and level of education

The desire for counselling by the GP and for referral to psychotherapy was not dependent on sex, age or level of education (see Table 4).

The patient group with previous experience of specialist psychotherapeutic treatment expected direct referral to a psychotherapist or other mental health specialist significantly more often than patients without this experience (Table 4).

In the desire for offers of psychosocial care, younger patients and patients with a higher level of education often cited relaxation techniques, self-help groups, family and couple counselling and referrals to counselling centres (Table 4).

Elderly patients (> 65 years, 40%) expected less of a healing or relieving effect than younger patients (< 65 years, 15%) ($\Pi^2 25.3$, $df 6$, $P < 0.001$). In addition, significantly more patients with a lower educational level (26%) expected less of a healing or relieving effect from psychosocial care than patients with a higher educational level (13%) ($\Pi^2 6.5$, $df 2$, $p < 0.04$).

Ranking of psychosocial treatment offers

Patients were asked to rank the importance of each of twelve different items in a list. The ranking (rated as "very important") of the treatment offers were:

Table 4: Psychosocial Treatment Expectations Dependent on Sex, Age and Level of Education (n = 220)

	Counselling by the GP	Relaxation techniques	Partner and family counselling	Referral to psychotherapy	Referral to mental health services
Age					
>65 y	27/49	13/49	6/28	21/49	7/31
<65 y	107/171 ($\Pi^2 = 0.89$; df = 1, p < 0.25)	91/171 ($\Pi^2 = 10.8$; df = 1, p < 0.001)	83/136 ($\Pi^2 = 20.3$; df = 3, p < 0.001)	95/171 ($\Pi^2 = 5.77$; df = 3, p < 0.13)	86/140 ($\Pi^2 = 16.6$; df = 3, p < 0.001)
Gender					
Female	93/118	67/131	35/131	72/131	57/131
Male	58/78 ($\Pi^2 = 0.52$; df = 1, p < 0.46)	37/89 ($\Pi^2 = 1.95$; df = 1, p < 0.16)	27/89 ($\Pi^2 = 0.34$; df = 1, p < 0.56)	44/89 ($\Pi^2 = 0.65$; df = 1, p < 0.42)	32/99 ($\Pi^2 = 1.26$; df = 1, p < 0.03)
Level of education					
Lower higher	63/100	38/100	20/100	50/100	30/100
	71/117 ($\Pi^2 = 0.12$; df = 1, p < 0.73)	66/117 ($\Pi^2 = 7.32$; df = 1, p < 0.057)	42/117 ($\Pi^2 = 6.68$; df = 1, p < 0.01)	p < 0.35)	59/117 ($\Pi^2 = 9.3$; df = 1, p < 0.002)
PP* Without	110/175	77/175	47/175	79/175	62/175
With	24/45 ($\Pi^2 = 1.36$; df = 1, p < 0.24)	27/45 ($\Pi^2 = 3.6$; df = 1, p < 0.05)	15/45 ($\Pi^2 = 0.7$; df = 1, p < 0.39)	37/45 ($\Pi^2 = 19.7$; df = 1, p < 0.001)	27/45 ($\Pi^2 = 8.97$; df = 1, p < 0.003)

* Note: pp = Patients with previous or present experiences with psychotherapy and/or present psychological problems.

1. Comprehensive information (74%)
2. Length of time (66%)
3. Active listening (60%)
4. Avoidance of treatment mistakes (60%)
5. Address anxiety and other emotional problems (56%)
6. Coping with distress of disease (51%)
7. Complementary medicine (48%)
8. Rapid relief of complaints (42%)
9. Health education (39%)
10. Holistic view (38%)
11. Prompt diagnoses (34%)
12. Modern technical equipment (31%)

Dissatisfaction was measured on the same items and showed a similar ranking. Whilst dissatisfaction with psychosocial issues and patient-centred activities ranked in the upper third, patients felt less dissatisfied with other treatments or technical equipment.

Discussion

The following main results confirmed the high degree of interest among patients in having their GPs involved in helping them with psychosocial problems [5,7,12] and the important role of the GP as a provider of psychosocial care and a gate-keeper to mental health specialists:

- Seventy-nine per cent of the patients considered a talk with the doctor regarding the psychological aspects of the illness to be important or very important
- Eighty-five per cent of all patients would definitely or probably accept psychosocial treatment within the framework of PPC.
- Counselling by the GP was the most important factor in patient expectations.
- Counselling and referral to psychotherapy was independent of sex, age and level of education.
- Patients want both advice and treatment from their GPs and referral to a specialist if needed.

The high acceptance of psychosocial care (79%) might be at least partly attributable to the patients not currently suffering from psychological problems. They respond to a question about what they would do if they were to have such problems, but this may not correlate with what they actually would do if such problems did arise.

Even elderly patients exhibited a pronounced desire to talk about psychological problems. They often have psychological and social problems and would like to talk about them but have no competent partner.

A lack of counselling could not be confirmed in this study. Contrary to other studies, we found that most patients did not doubt the psychosocial skills of their doctors [13]. Whilst general levels of satisfaction with the psychosocial care provided by GPs were high, questions of a more detailed and specific nature revealed greater levels of dissatisfaction (e.g. length of time 36%, comprehensive information 27%, active listening 23%).

As other studies have demonstrated, the main reason patients believe psychological problems are not addressed is the doctors' lack of time. Interestingly, training in interviewing skills improved the process and the outcome of care without lengthening the visits [14]. In contrast to the study by Cape [5], who found that 25% of patients had the feeling that the doctor was not interested in their problems, our study showed that only 3% of patients had the impression the doctor was not interested in their problems.

As in previous studies [15], patients clearly tend to distinguish between the doctor's technical skills and the doctor's interpersonal skills.

Limitations

The limitations are firstly related to the different mental health care systems. The German mental health care system is tripartite: 1. Psychosocial Primary Care by general practitioners, 2. Approximately 10 % of specialists like gynaecologists, paediatricians, dermatologists, internists have additional training in psychotherapy and 3. Psychiatrists and medical or psychological psychotherapists. The access to mental health services is easier than in other countries. In Germany, the patient is free to select the doctor. Many patients go immediately to a psychotherapist. There is full coverage of psychotherapeutic fees by private and public health insurance. With the introduction of psychosocial primary care, the psychosocial competence of general practitioners has improved considerably in the past 15 years. This is comparable to the development in other European countries e.g. United Kingdom, Netherlands, Switzerland, Scandinavia.

But also for other reasons the results can only be generalized to a limited extent. The sample of general practitioners may not be representative for the general population of GPs. The number of participating doctors (n = 10) and patients (n = 220) was small. The doctors were trained in PPC and their participation in training was partly self-motivated and partly motivated by interests in billing the

health insurance companies. The patients' attitudes toward talking about psychological problems may be influenced by the willingness of their doctors to participate in such discussions.

Concerning the recruitment of patients, it must be assumed that more people opposed to psychosocial medicine than those in favour of it are in the group that refused to participate, thereby resulting in an underestimate of real patient need.

Conclusions

As indicated from other studies, Psychosocial Primary Care (PPC) is very well accepted by patients and doctors. Dissatisfaction exists mainly with respect to doctor-patient communication skills, such as provision of information and advice, and active listening. These points should be given more attention in future training courses. As found in other studies, the efficacy of non-specific psychosocial interventions is limited [16]. Therefore, the future goals are to develop specific psychosocial interventions for frequent mental disorders, such as somatoform disorders, depression and anxiety. Up to 70 % of patients with depressive symptoms are under treatment by a general practitioner. Cooperation between general practitioners and psychiatrists has been instituted to optimise care of these patients. This "Competency Network Depression" is supported by the Federal Ministry of Education and Research (BMBF) and is aimed at early recognition of the large group of patients with depressive symptoms in general practice and adequate treatment in a cooperative program.

Competing interests

None declared.

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